



2017 Camper Health Form

IMPORTANT: Health Form must be submitted to our attention upon registration. Updates can be submitted later by email. Please ensure it is filled out completely & accurately. Campers cannot attend camp without a current health form on file prior to camp.

CAMPER INFORMATION: *(print clearly)*

Last Name: _____ First Name: _____ Middle Name: _____
 Birthdate: (mm/dd/yyyy) _____ Camper's Age on January 1st, 2017: _____ Gender: Male Female
 Household Address: _____
 City/Town: _____ Province/State: _____ Country: _____
 Postal/Zip Code: _____ Home Phone#: _____

PARENTS / GUARDIANS & EMERGENCY CONTACTS: *(print clearly)*

★ ★ ★ List in order who should be contacted in case of emergency – be sure to include parents/guardians: ★ ★ ★

1st Contact: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/> Dr. First & Last Name: _____ Relationship: _____ Home Phone: _____ Work Phone: _____ Cell/Pager: _____ Summer #: _____	2nd Contact: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/> Dr. First & Last Name: _____ Relationship: _____ Home Phone: _____ Work Phone: _____ Cell/Pager: _____ Summer #: _____	3rd Contact: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/> Dr. First & Last Name: _____ Relationship: _____ Home Phone: _____ Work Phone: _____ Cell/Pager: _____ Summer #: _____
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Camper's Health Card #: _____ **Expiry Date:** _____

Out-of-Canada campers: indicate any medical plan, numbers & billing address, (attach separate piece of paper if necessary)

Family Doctor: _____ **Phone:** _____

Family Dentist / Orthodontist: _____ **Phone:** _____

Immunization Dates: Chicken Pox: _____ Hepatitis B: _____ Meningitis: _____

Diphtheria/Pertussis/Tetanus/Polio: _____ MMR (Measles/Mumps/Rubella): _____

A photo for emergency purposes will be taken on arrival day

ALLERGIES: Does your child have any allergies. Be specific, attach separate page if necessary.

★ Please note, we do NOT use or allow foods/snacks that contain nuts or traces of nuts. ★

Indicate Type: Drug, Food, Environmental, Insect, Other	Allergen (please be specific)	Type & Severity of Reaction (Indicate if life-threatening)	Management / Treatment / Medication	Date of Last Reaction

EPI-PEN: Does your child require an EpiPen? No Yes - If yes, please provide details about your child's anaphylaxis, including the date and description of any reaction. You **MUST** fill out an [ANAPHYLAXIS EMERGENCY PLAN FORM provided in the Registration package](#) and bring this to camp on arrival day. _____

***** If your child is required to carry their EpiPen (i.e. bee/wasp allergy), please provide two non-expired EpiPens; one for your child to carry with them and one to keep onsite. *****

DIETARY RESTRICTIONS: Vegetarian Vegan Lactose Intolerant Gluten Free Other: _____

2017 Camper Health Form (continued)

Last Name: _____ **First Name:** _____

ASTHMA/INHALER: Does your child have asthma? No Yes - If yes, indicate severity? Mild Moderate Severe
Made worse by activity. What are the triggers for these attacks? _____

If your child will be carrying his/her puffer with them, please bring an extra non-expired puffer to be left in the onsite. If your child has used their puffer in the last year, they are required to have a puffer at camp.

MEDICATIONS AT CAMP: Will your child be taking any medications while at camp (prescription or homeopathic)?

If yes, list medication, dosage, schedule, route, and reason for medication: _____

MEDICATIONS AT HOME: Does your child regularly take any medications that will not be taken at camp?

HEALTH HISTORY: Has your child experienced or is currently experiencing any of the following conditions:

- | | | |
|---|--|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nightmares / Terrors |
| <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> Ear Infections / Hearing Problems | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Back / Neck Pain or Injury | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Sinus infections |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Fetal Alcohol Syndrome | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Behavioral Issues | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Blackouts / Fainting | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hernia | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Homesickness | <input type="checkbox"/> Sprains, Strains, or Fractures |
| <input type="checkbox"/> Chrons / Colitis / IBS | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Constipation / Diarrhea | <input type="checkbox"/> Menstrual Difficulties | <input type="checkbox"/> Visual Problems / Wears Glasses/Contacts |
| <input type="checkbox"/> Dental Braces / Caps / Bridges | <input type="checkbox"/> Mental Health Issues | <input type="checkbox"/> Weight Concerns / Eating Disorder |
| <input type="checkbox"/> Developmental Delays | <input type="checkbox"/> Motion Sickness | <input type="checkbox"/> Other, please explain: |

Other please explain:

2017 Camper Health Form (continued)

Last Name: _____ First Name: _____

OPERATIONS / HOSPITALIZATION / SERIOUS INJURY:

Has your child had any operations, ever been hospitalized, or had a serious injury. If yes, please explain giving details, date of occurrence, any lingering effects on child's health, and any signs of illness that camp staff should look out for. _____

OVER-THE-COUNTER MEDICINE AT THE HOSPITAL:

May the following over-the-counter medications be given to your child while in hospital care, if deemed necessary by a health professional?

Acetaminophen (Tylenol) Antacids Antihistamines (Benadryl) Gravol Ibuprofen (Advil)

Is there anything the camp needs to be aware of when giving any of the approved over-the-counter medications to your child?

ILLNESSES: Has your child had any of the following diseases? If yes, please explain (date, details).

____ Chicken Pox (Varicella) ____ Hepatitis ____ Measles ____ Mononucleosis
____ Mumps ____ Rheumatic Fever ____ Scarlet Fever ____ Whooping Cough

ACTIVITY RESTRICTIONS: Camp Superhero Kids Yoga Camp activities happen indoors and outdoors.

Does your child have any restrictions on activity? No Yes - If yes, please explain: _____

ADDITIONAL INFORMATION: Please list any other medical information the camp should know about your child.

IMPORTANT REMINDERS - please read carefully!

- I understand that all information collected will be used to diagnose, treat or maintain my child's physical or mental health and to assist in preventing disease or injury or to promote health. This information is considered to be confidential and will be shared amongst health care providers as needed; ie: Walk in Clinic or Emergency Health Care Providers. This information will only be shared with the Camp Director and Camp staff on a need to know basis to ensure the physical and mental health of my child.
- To the best of my knowledge, my child is in good health. **I will notify the camp in writing prior to arrival if there is any change in my child's health, or he/she is exposed to any communicable disease within 3 weeks prior to arrival at camp.**
- In the case of a medical emergency, I understand that every effort will be made to contact parents or guardians. In the event I cannot be reached, I hereby give permission to the physician/nurse selected by the Camp Director to hospitalize, secure proper treatment, order injection, anesthesia or surgery for my child as named above.
- I agree to reimburse the camp for any prescriptions or medical expenses incurred for this camper.
- **I will do a head lice check on my child regularly and within 3 days before arriving at camp.** Campers found to have head lice on arrival will not be allowed to enter camp until the matter has been resolved. There will be no refund of camp fees.
- **I will submit any changes to this health form in writing to the camp prior to arrival**

★ **Signature of Parent/Guardian:** _____ **Date:** _____